INFORMATION

Social Aspects of Medicine

A Special Report by the Bureau of Research and Planning on Recent Literature on Social, Economic and Organizational Problems

This report calls attention to several recent articles and publications which deal with the financing and organization of medical care in the United States. They contain discussions of issues and problems with which all physicians should be aware.

The California Medical Association, through its committees and commissions, has been actively engaged for some time in studying many of the problems to which the authors of the various articles refer. Among these committees are the Bureau of Research and Planning which has conducted several studies for use by the Association and its members. Another is the newly created Committee to Study the Role of Medicine in Society of the California Medical Education and Research Foundation.

THE PAST FEW MONTHS have seen the appearance of a number of articles by physicians, behavioral scientists, and organizations, which concern themselves with the financing, provision, and organization of medical care. Some of the articles confine themselves to one or two topics of current interest; others deal with a wide spectrum of issues and developments. Most of them reflect a major recurring theme of dissatisfaction with the status, and/or with the progress that is being made.

The preoccupation of the physician with the scientific aspects of his profession frequently precludes many opportunities he may have to become aware of the issues being discussed in the stream of professional and lay publications which reflect the opinions, attitudes, and findings of the authors and which often also reflect the attitudes and philosophies of other groups in society who desire certain changes for social and economic reasons.

The purpose of this report is to call attention to a few of these recent articles and publications, and to acquaint physicians with their highlights. Regardless of the points of view expressed, or observations made, the mere fact of their publication and wide distribution among opinion leaders and sophisticated audiences reflects the increasing attention being given to issues with which most physicians are familiar and to approaches, avenues of inquiry, and suggested solutions, some of which constitute departures from current philosophies held by many physicians.

No significance should be attached to the order in which the following digests are presented other than to note that if most of them contain cautions, criticisms, and suggestions for change or improvemen, their value lies in calling attention to the social forces at work which can ultimately affect, in one way of another, the practice of medicine and the delivery of medical care to the American people.

Jaco[1] discusses the social and organizational aspects of medical care and the attitudes of a sample of the American public toward the medical profession. While almost 9 out of 10 people are entirely satisfied with the care and treatment they receive from physicians; while more than 4 out of 5 people believe that their chances of having good health today are better than they were 30 years ago, and while the physician ranks highest in occupational prestige score among other professional persons, he cautions against overdue optimism ". . . if the symptoms of discontent spread and become malignant." He cites increasing demands of the American public and the organizational attempts to cope with them as factors to be considered. He also refers to the social and economic changes during the past century, and the emergence of the "affluent society" which

> ". . . suggest a trend among certain components of American society to view medical care as a tangible *product* to be consumed and supplied on demand. Still other segments of the population may come to view good medical care as a 'right' along with other constitutional freedoms and guarantees."

While the attitudes of *all* segments of American society may not have changed significantly during the preceding decades, Jaco calls attention to the fact that the aged, the less educated, and the lower-income segments of the population ". . . exhibited the more divergent uses and attitudes toward medical care. . . ." One of his conclusions is that,

> "All in all, it is likely that any changes in attitudes that the American people may have toward medical care are related to their changes in attitudes toward other components of American society and perhaps toward life itself."

He cites the need for further research and studies on changing attitudes and values in contemporary American society.

Hill[2] dissects the image of the American physician in an article which might well have been entitled, The American Physician's Dilemma, and concludes that the honeymoon is over between the public and the physicians, due to the impersonal nature of medical care induced by increasing

specialization and advanced technology. While recognizing the emphasis of organized medicine on scientific progress, and the acceptance of this role by the public, he is less optimistic of the public's views toward the profession's position on political, social, and economic issues. He devotes quite a bit of space to the methods of charges to the public and the type of physician-patient relationship which has evolved. Despite his attempts to explain the physician's attitudes, philosophy, and behavior, he concludes that while the public respects the medical profession, it does not love it, and that ". . . the problems of the American doctor are born, not of despair, but of progress."

Folsom[3] concerns himself with the problem of appraising tomorrow's health services on the basis of the community's recognized needs and resources. Manpower, medical education, medical research, utilization and cost of health facilities and services —all are touched upon in his search for assessment of future needs. He describes the study now being conducted by the National Commission on Community Health Services, under a grant from HEW, the Kellogg Foundation, and the McGregor Fund, to the American Public Health Association for a study which the APHA and the National Health Council are sponsoring. The study, which will involve organizations and physicians in a number of communities throughout the country, will also include in its task-force studies physicians and other community leaders from a wide range of organizations and interests. The study will culminate in a national conference the recommendations of which could have a significant impact upon future community planning and action. His philosophy can be summed up by his concluding remark:

> "The wise use of our resources must be a concern of government at all levels and the private volunteer agencies and the individual citizen as well."

Mather[4] discusses the present and future role of the worker in public health and his interdependence with other disciplines if optimal health is to be provided the public. He summarizes his thesis by stating:

> "He is a member of a complex team not only within his own organization but within the larger community. He has much to contribute through his own efforts and by his leadership. His role is changing and will continue to change. With vision, imagination, determination, industry, cooperation, judgment and adaptability he can ensure that the discipline of public health attains full maturity and, in so doing, serve his people best."

The article discusses the enlarging horizons of public health, its greater involvement with personal health services, and a more dynamic role as part of the health team. Although the article attempts to examine the role of the person in public health in Canada, it draws upon American developments and thought, and poses questions for future resolution.

The Statement on Hospitals[5] by Labor's executive council is more than the title implies. It is, rather, a platform of position and action which reflects dissatisfaction with today's health care services, and recommends broad proposals for community and legislative action. It proposes various planning and organizational steps which affect hospitals as well as the organizational form of medical practice. Among some of the topics discussed are: hospital planning, quality of medical care, direct service and full payment plans, comprehensive medical services, prepaid group practice, and health care costs—ending in a recommendation for the AFL-CIO to establish a national Medical Advisory Committee.

Davis[6] touches upon several of the issues discussed by the other authors, and adds some more to them. He raises two points which are of special interest. One of these which deals with the relationship of the physician in private practice to the hospital declares that,

> ". . . the typical American general hospital, a non-profit, non-governmental institution, has become a place provided by the community for the private practice on bed cases . . . how many physicians are conscious of this gift and of its implied obligations?"

The second point is his recommendation for a national Committee of Physicians for Progress in Medical Care which would operate under the auspices of "an existing nationwide, non-political body" for the purpose of defining the goals of adequate medical care, its quality, and organization, and which would serve as a kind of body of arbitration on virtually any issue affecting medical care. The article is critical of the role of the A.M.A. While not in favor of a "universal scheme of governmentally organized and financed medical service," he favors . . . "by functional experimentation, some voluntary, some governmental" system of care to "encourage and guide experimentation."

Peterson's[7] article has a subtitle which states that, "The revolution in medical science during the past three decades has brought great changes in the way medicine is practiced and is creating urgent problems in the organization of medical care."

The urgent problems he describes deal with the social and economic issues of medical care; the emphasis of the article is on the quality of care rendered, the supply and composition of physicians,

the competency of their performance, their organization into groups or into group practice with prepayment, and developments in hospital organization and staff relationships. He argues for the extension of group practice with prepayment and states that,

> "The most intriguing unanswered question is why physicians, who are so concerned about government intervention in health insurance, have not tried to forestall it by imitating more widely the successful precedents established by their colleagues and nongovernmental lay institutions."

In addition to the preceding articles, the physician should also become familiar with other recent publications and articles which treat the issues referred to, and which contain the views of persons whose work or interests are closely identified with the health care services. They are:

Medicine and Society: The Annals of the American Academy of Political and Social Science, March 1963. Philadelphia ($2.00).

Somers, Herman M., and Somers, Anne R.: Doctors, Patients, and Health Insurance. Doubleday Anchor (Paperback). 1963 ($1.95).

Follmann, J. F., Jr.: Medical Care and Health Insurance, Richard D. Irwin, Inc., 1963. Homewood, Illinois ($10.60).

Robins, R. B., Editor: The Environment of Medical Practice, Year Book Medical Publishers, Inc., Chicago, 1963 ($6.50).

Medical Care and Family Security, Norway, England, U.S.A. Prentice-Hall, Inc., 1963. Englewood Cliffs, N. J. ($6.50).

The Health Care Issues of the 1960's. The record of a national symposium. Group Health Insurance, Inc., 221 Park Avenue South, New York, 1963. (Paperback, no price indicated.

Lord Taylor: America's Medical Future, A Briton's View. The Nation, September 28, 1963.

Gamson, William, and Schuman, Howard: Some Undercurrents in the Prestige of Physicians, The American J. of Sociology, Jan., 1963, U. of Chicago Press. ($1.75).

Government and Medicine in the United States (8 articles), Current History, August, 1963. ($.85).

The series of eight articles in the August issue of *Current History* provides a broad overview of the health care issues being discussed on the national scene. They offer a distillation of the arguments and discussions dealing with the extent of governmental responsibility in this field.

. . . Odin Anderson, Ph.D., presents a sweeping historical perspective of this problem, noting that, "Our health services are now enormous strains as a result of their own success during the past 30 years." He argues against the measuring of the effectiveness of health services on the basis of mortality and morbidity rates, in favor of the extent to which, ". . . anxiety is relieved, pain alleviated, and the patient assisted in adjusting to disabilities . . . as one gets older."

. . . Professor William Carleton traces the changing relationships between the individual and the Federal Government. He notes that, "Historically . . . the entering wedge for direct individual medical help to civilians by the federal government came by way of aid to veterans of the armed services." He states that, ". . . there is a wide-spread belief that the veterans' hospitals represent too limited an experience from which to deduce valid conclusions about the operation of a general system of government medicine in the United States."

. . . Professor Roy Lubove deals lengthily with the origins of the demand for a national health program in the days of the New Deal, and the nature and the forms of opposition to a national health plan. One of the significant conclusions of his article is that, "In the final anlysis, the A.M.A. position on the Wagner bill and its relationship generally to the evolution of a national health program were based less on considerations of economic advantages or, for that matter, the concrete medical needs of the nation, than upon more intangible fears concerning the freedom and status of the physician."

. . . Marion Folsom reviews the first decade of activity of the Department of Health, Education, and Welfare, of which he was formerly Secretary. He states that, "The function of the federal government is mainly one of leadership and stimulation, and overall action only in specific problems that can only be handled on a nationwide basis."

. . . Harry Becker reviews the history of prepayment and insurance programs, including group practice with prepayment plans, and declares that, "There is much that needs to be learned about the most economical ways to approach the problem of financing and organizing health care under prepayment arrangements." He asserts that, "The fate of voluntary health insurance . . . may well rest with Blue Cross . . . a public decision must be made . . . on the issue of how much support is to be given community-based non-profit plans, vis-à-vis other types of prepayment organizations."

. . . Wilbur Cohen argues for the social security approach to financing the health care of the aged, maintaining that, ". . . the individual would make contribution during his working years and receive hospital insurance protection in old age—a long step toward the prevention of dependency."

. . . Dr. Edward Annis argues against the position taken by Mr. Cohen by citing the accomplishments of the Kerr-Mills Law and stating that, "History shows that government control over health care is either the first step or one of the early steps toward government domination of all aspects of a people's life."

. . . Professor Seymour Harris discusses the British and American experiences and cites several

reasons why a national health insurance plan might be desirable or become an eventuality. He states that, although ". . . there is a case for national health insurance, (but) it is not nearly so strong a case as one could have made in the 1930s or the 1940s." Although he is not unsympathetic to the national health service in Great Britain, he refers to the great expansion of voluntary health insurance, the rising standard of living, and the capacity of the American people to increase their contributions for medical care as reasons for weakening the case for a national health insurance program in the United States.

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REFERENCES

1. Jaco, E. G.: Medical care: Its social and organizational aspects, N.E.J.M., July 4, 1963, pp. 18-22. (This article is one of a series being published currently in the N.E.J.M.)

2. Hill, E.: Death of a legend in an era of miracles, The Saturday Evening Post, June 15, 1963.

3. Folsom, M. B.: Today's health needs and tomorrow's services, J. Pub. Health, June, 1963, pp. 863-870.

4. Mather, J. H.: Attainment of optimum health, Canadian Med. Assn. J., June 27, 1963, pp. 175-181.

5. Statement on Hospitals, AFL-CIO Executive Council, February, 1963, Washington, D. C.

6. Davis, M. M.: America Challenges Medicine, Lecture, Graduate School of Business, Univ. Chicago, May 23, 1963.

7. Peterson, O. L.: Medical care in the U. S., Scientific American, Aug. 1963, pp. 19-27.

Enrollment Under the Federal Employees Health Benefits Program

A Report of the Bureau of Research and Planning, California Medical Association

Active and retired federal employees, together with their dependents, represent the single largest group of persons enrolled in any voluntary health insurance program in the United States. The extent of their coverage and enrollment is of particular interest to physicians in California since this state has the largest proportion of all federal employees enrolled among all states.

Of the almost 5¾ million federal employees and their dependents, enrollment in California was almost 609,000 or slightly over 10 per cent of all those covered. Better than 3 out of 5 individuals covered were enrolled in service type plans both in the U.S. and in California. Of all persons enrolled in comprehensive group practice and individual practice plans in the U.S., almost one-half were in California alone.

Almost 4 out of 5 individuals enrolled were in high option plans. ". . . an indication that most employees were satisfied with their initial choice of plans."

As OF June 30, 1962, a total of 5,755,000 active and retired Civil Service employees and their dependents were covered under the Health Benefits Program of the United States Civil Service Commission [enrollment within and without the United States was slightly over 5.8 million]. California had the largest enrollment with almost 609,000 or slightly over 10 per cent of all those covered.

Enrollment in the two government-wide plans for the United States was over 4½ million, with 3.2 million (71.1%) in the government-wide service plan and 1.3 million (28.9%) in the government-wide indemnity plan. In California almost 384,000 individuals were enrolled in these two plans; 212,000 (55.2%) in the service benefit plans and 172,000 (44.8%) in the indemnity plan.

Twelve employee organization plans had an enrollment of 889,000 in the United States and almost 63,000 (7.1%) in California.

National enrollment in 23 comprehensive medical plans (group practice and individual practice) was almost 343,000 of which 162,000 or 47 per cent were in California alone. Six of the 23 group and individual practice plans were in California.

Over 60 per cent of all persons enrolled in the United States and in California were in service type plans.

Source: U.S. Civil Service Commission, Bureau of Retirement and Insurance. U.S. Government Printing Office, 1963.

The open enrollment season in October, 1961, which gave federal employees an opportunity to change plans or to move from one option to another resulted in a change of plan by only about 5.3 per cent of all federal employees. Of the 54,328 employees who changed plan options, only 2,426 (4.5%) selected the low option; 95 per cent moved from the low to the high option. The report from the Civil Service Commission states that this is ". . . an indication that most employees were satisfied with their initial choice of plans."

Of the 73,000 annuitants (dependents not included) under the retired federal employees health benefit program in the United States, 8,200 or slightly over 11 per cent are in California.

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